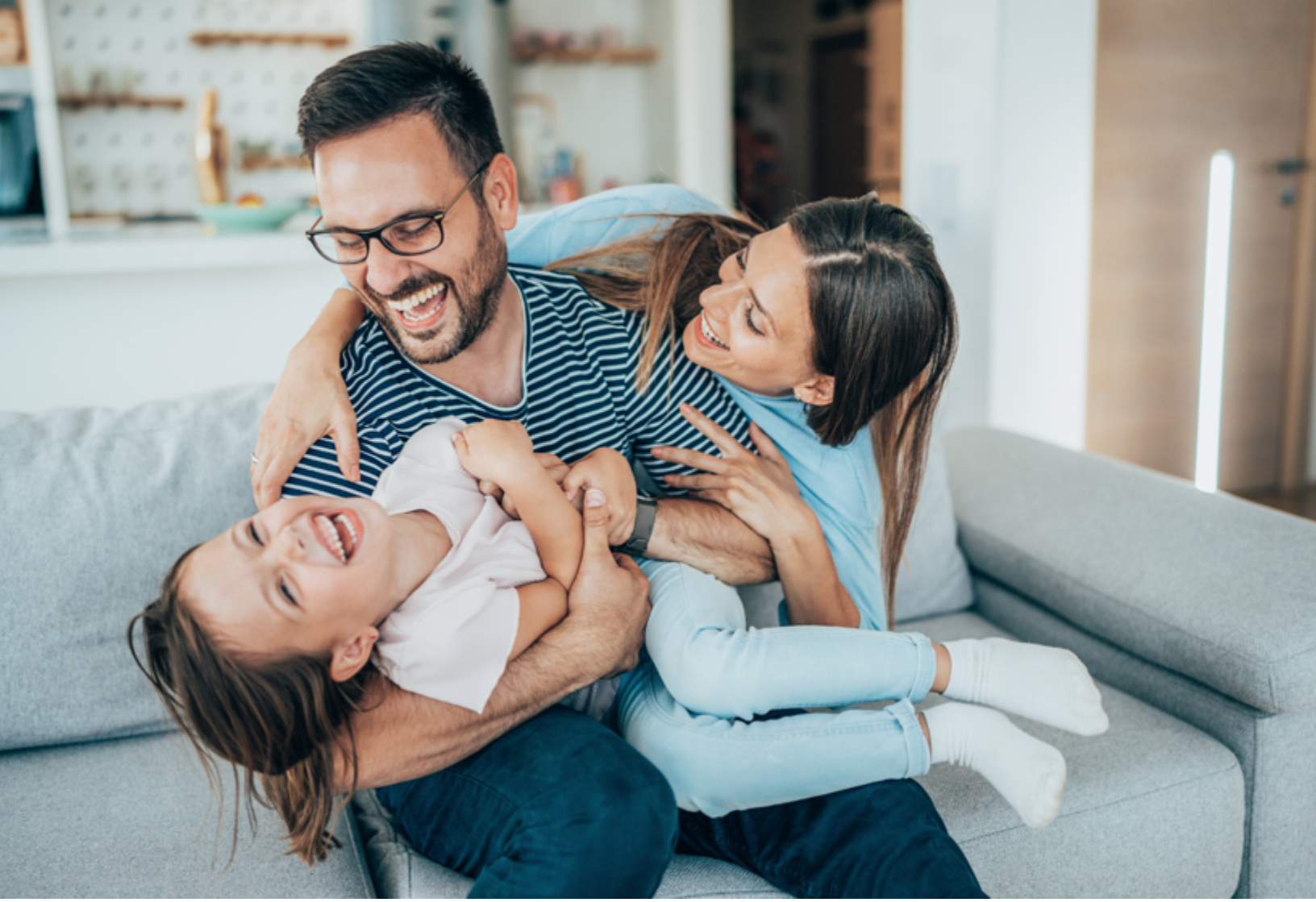

20 BENEFITS 26 GUIDE

Sila SERVICES

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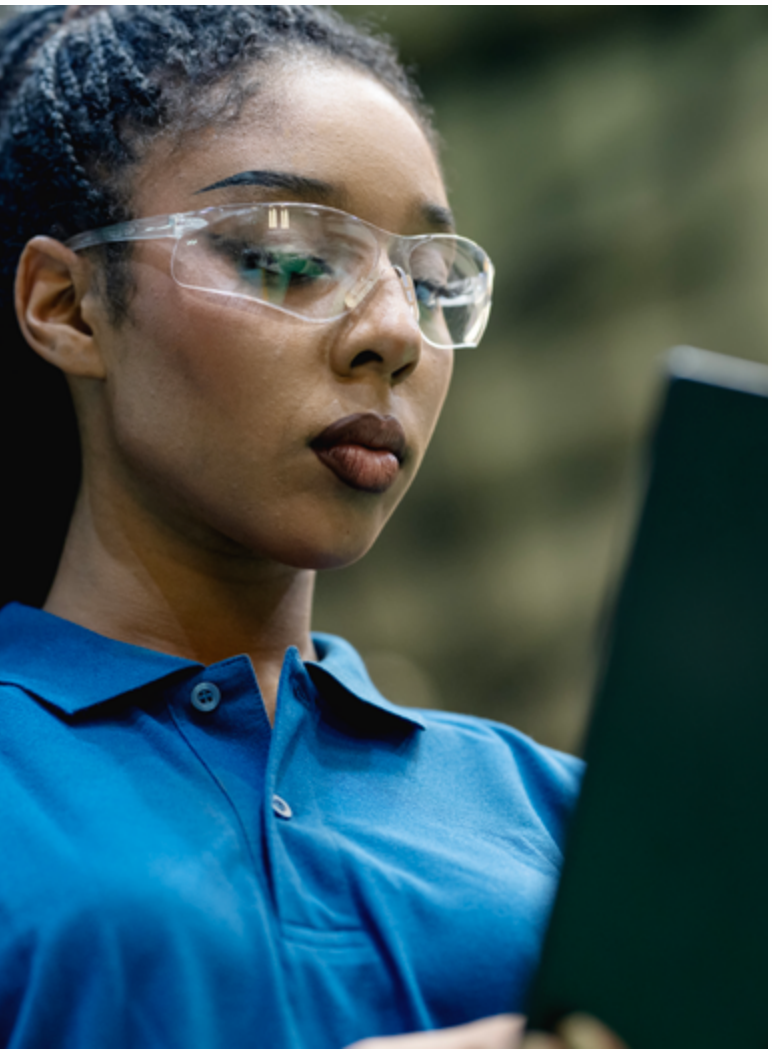


Sila provides a competitive, valuable benefits program that meets the diverse needs of our employees and their families. This Benefits Guide provides details about the various benefits and programs we offer, so you can choose the benefits that are right for you and get the most out of them all year long.

Review this guide carefully as it summarizes your plan options and offers helpful tips for getting the most value from your benefit plans.

Keep in mind that this guide is not your only resource. Anytime you have questions about benefits or the enrollment process, you can contact your Human Resources representative by calling 610.491.9409 or emailing benefits@sila.com. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) provided by the insurance carrier.

Eligibility & Enrollment

Benefits Website

Visit your benefits website at mysilabenefits.com for additional information.

Employee Eligibility

You may enroll in the benefits program if you are a regular full-time employee who is actively working a minimum of 30 hours per week. If you are a new hire, the enrollment window is open 30 days post-date of hire. Benefits become effective the first day of the month following 30 days of employment.

Dependent Eligibility

As you become eligible for benefits, so do your eligible dependents. In general, eligible dependents include:

- Your spouse. This includes your legal spouse, common law spouse, domestic partner*, and civil union.
- Your children up to the age of 26. This includes your natural children and those of your spouse, your adopted children, stepchildren, foster children, or children obtained through court-appointed legal guardianship. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided.

**If you plan to enroll your domestic partner, you will be required to submit a domestic partner affidavit.*

Qualifying Life Events (QLE)

If you experience a qualifying life event, you can make changes to your coverage within 31 days of the event. You will need to provide proof of the event. Examples of qualified life events include:

- Birth / Adoption / Marriage / Divorce
- Dependent child reaches age 26
- Spouse / dependent loses or gains coverage
- Death of spouse / dependent child

Lockton On Call

All full-time employees have access to the benefits helpline through Lockton On Call. Reach out by phone or email to receive one-on-one support.

When should you use Lockton On Call?

- If you have questions on Sila's comprehensive benefits package.
- If you need help understanding your benefits.
- If you have claims questions.

Benefits Helpline

Monday - Friday, 8am to 7pm EST

SilaBenefits@lockton.com

866.430.0125

How to Enroll

Take action! Be sure to enroll if you want benefits for the 2026 plan year. Your current benefits will NOT roll over and you will not have coverage in 2026 if you do not enroll during open enrollment.

This is your opportunity to review, confirm, and make any necessary changes to your current elections to ensure you and your family have the right coverage.

Remember: Changes to your benefits can only be made during open enrollment or if you experience a qualifying life event.

Go to **workforcenow.adp.com**

First-time users: Click on the registration link in the email sent to you by your admin and register as a new user.

Create an account and create your own username and password.

Click "Let's Begin" to complete your required tasks.

Make sure to have you and your dependents' Social Security numbers and dates of birth on hand for the enrollment process. If you have questions about enrolling in coverage, reach out to your HR team at 610.491.9409, or email **benefits@sila.com**.

Updates for 2026!

Highmark Will Be Our New Medical Provider!

We're excited to partner with Highmark this year to bring you enhanced medical coverage. This change was made with your needs in mind, offering improved member support, user-friendly tools to manage your care, and access to a broad, high-quality provider network. Whether you're scheduling a routine visit or managing a health condition, Highmark is here to make your healthcare experience smoother, more personalized, and easier to navigate.

Outlined below are a variety of different programs that are available to those enrolled in a Sila medical plan.

Additional Programs Available Through Highmark

BABY BLUEPRINTS

Baby BluePrints is a free program that offers educational information on all aspects of pregnancy, plus one-on-one support from a women's health specialist.

It's covered by your Highmark plan, and has everything you need to stay calm, confident, and informed while you wait for your little one to arrive.

Call 866.918.5267 to get started.

MENTAL WELL-BEING

Starting January 2026, you will have access to Mental Well-Being, powered by Spring Health. This mental healthcare option can help you or your family get the right care, right away, and make room for a brighter future.

Download the My Highmark app from your phone's app store or visit MyHighmark.page.link/MentalWellBeing today.

HIGHMARK WELLNESS COACH

Through your new Highmark medical plan, you can receive personalized coaching from your own wellness coach. This program helps create a customized plan to help you:

- Lose weight
- Quit smoking
- Sleep better
- Reduce stress
- Manage chronic conditions

Call 800.650.8442, Monday - Friday, to get connected with a coach, or visit HighmarkHealthCoachBlueShield.com to learn more.

BLUE 365 DISCOUNTS

Blue365 is Highmark's discount program, which offers you savings on a variety of products. When you register at blue365deals.com, you get access to offers on select Garmin and Fitbit products through Heart Rate Monitors USA, and thousands of gyms nationwide for a low monthly fee through Tivity Health.

To help you care for the whole you, Blue365 also offers discounts on vision, dental, and hearing products and services. Register at blue365deals.com to get started.

WELL360 VIRTUAL HEALTH

Save time and get care — wherever it's convenient for you. With virtual visits, you can see a provider for symptoms and conditions that can be treated from home. You can even have prescriptions and refills sent to your preferred pharmacy.

Through this program, you also have virtual access to behavioral health and urgent care. Please note, certain cost-share may apply.

Well360 Virtual Health is available in the My Highmark app under the Get Care section, or you can visit MyHighmark.com to learn more.

24/7 NURSELINE

Through your Highmark medical plan, you are able to access a 24/7 Nurseline to answer any medical concerns during off hours. Call the phone number on the back of your ID card or from the My Highmark app to get support from a registered nurse anytime.

Here Are Some Terms You'll See

COINSURANCE: Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, if your medical plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The medical plan pays the rest of the allowed amount.

COPAY: A fixed dollar amount you pay for a healthcare service. The amount can vary by the type of service. Your copays will not count toward your deductible, but will count toward your out-of-pocket maximum.

DEDUCTIBLE: The amount you owe for covered healthcare services before your plan begins to pay benefits. For example, if your deductible is $2,800, your plan won't pay anything until you've met your $2,800 deductible for covered healthcare services that are subject to the deductible. In-network preventive care is not subject to the deductible, as it is covered 100% by the medical plan options.

EMBEDDED DEDUCTIBLE: If your family medical coverage has an embedded deductible, that means if one family member reaches the individual deductible, they will begin to share in the cost of care through coinsurance—they do not need to reach the family deductible before coinsurance begins. Once the expenses for all other family members reach the family deductible, coinsurance will begin.

EXPLANATION OF BENEFITS (EOB): A statement from the insurance company showing how claims were processed. The EOB tells you what portion of the claim was paid to the healthcare provider and what portion of the payment, if any, you are responsible for.

EVIDENCE OF INSURABILITY (EOI): EOI is a short health questionnaire that some insurance may require you to apply for certain types or amounts of coverage—like life or disability insurance—outside of your initial eligibility period or above a guaranteed amount. It helps the insurer understand your health status before approving the coverage.

IN-NETWORK VS. OUT-OF-NETWORK: A network is composed of all contracted providers. Networks request providers to participate in their network, and in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your costs will be higher because you will not receive the discounts the in-network providers offer.

OUT-OF-POCKET MAXIMUM: The out-of-pocket maximum is designed to protect you if you have a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance and copays that come out of your pocket. After you have reached the annual out-of-pocket maximum, the plan pays the remaining covered services at 100%.

PREVENTIVE CARE: Routine healthcare services can minimize the risk of certain illnesses or chronic conditions. Examples of preventive care services include physical exams, mammograms, flu vaccines, prostate tests and smoking cessation.

REASONABLE AND CUSTOMARY: The amount of money a medical plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers reasonable and customary, you may have to pay the difference.

Medical Coverage

Highmark | www.highmark.com | 800.241.5704

Sila is committed to helping you and your dependents maintain health and wellness by providing you with access to the highest levels of care. You are offered the following three medical plan choices for 2026 through Highmark: two PPO plans and one High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). If you enroll in the White plan, you are eligible to contribute to a Health Savings Account (HSA). More information on HSAs can be found on page 12.

How to Find a Provider

1. Visit **highmark.com**
2. In the top right, select **"For members"**
3. Click **Find Care**
4. Scroll down to determine which region applies to you

Why It's Important to Use In-Network Providers

Visiting an in-network provider helps you get the most out of your health plan. These providers offer services at discounted rates compared to services you would receive out-of-network, which means lower out-of-pocket costs for you. Plus, your insurance covers a larger portion of the bill when you stay in-network—helping you avoid surprise charges and keep your healthcare more affordable. Please note, there is no out-of-network coverage for the White and Blue medical plans.

Highmark

	ORANGE PLAN	WHITE PLAN	BLUE PLAN
Calendar Year Deductible			
Individual	$2,000	$2,500	$5,000
Family	$4,000	$5,500	$10,000
Out-of-Pocket Maximum			
Individual	$5,500	$7,000	$7,000
Family	$11,000	$10,000	$14,000
Coinsurance (you pay)	20%	30%	30%
Preventative Services	100% covered	100% covered	100% covered
Physician Office Visits			
Primary Care	$30	$40 after ded.	$40
Specialist	$50	$70 after ded.	$80
Urgent Care	$50	$100 after ded.	$80
Telemedicine	$25	30% after ded.	$40
Hospital Services			
Inpatient	20% after ded.	30% after ded.	30% after ded.
Outpatient	20% after ded.	30% after ded.	30% after ded.
Emergency Room	$300	$200 copay and 30% after ded.	30% after ded.

Download the My Highmark app or visit MyHighmark.com today.

Prescription Coverage

SmithRx

PRESCRIPTION DRUGS			
30-Day Supply	**ORANGE PLAN**	**WHITE PLAN**	**BLUE PLAN**
Tier 1 - Generics	$15	$15 after ded.	$15
Tier 2 - Preferred	$40	$40 after ded.	$40
Tier 3 - Non-Preferred	$70	$70 after ded.	$70
90-Day Supply			
Tier 1 - Generics	$30	$30 after ded.	$30
Tier 2 - Preferred	$80	$80 after ded.	$80
Tier 3 - Non-Preferred	$140	$140 after ded.	$140

Additional Resources Through SmithRx

CONNECT 360 ACCESS TRADITIONAL PROGRAM

This program is designed to help you enroll in copay assistance programs to help lower your cost of medications. If you are taking an eligible medication, you can complete **three transitional fills** while you're enrolling in the program. **If you do not enroll prior to your fourth fill, your claim will be rejected at the pharmacy.**

If you are taking qualifying medications, SmithRx will reach out to you. **This is how the process will look:**

- SmithRx will make multiple outreach attempts via phone, email, and text messages to inform you of the program. You can also call SmithRx at 844.385.7612 to get started!
- SmithRx will explain how to enroll in a copay card. This only takes 5 minutes to complete.
- Once you're enrolled, SmithRx will help you coordinate with your preferred local in-network pharmacy. Your monthly fills will be available at a low cost or a **$0 copay at your preferred pharmacy.**
- If you need a new medication, your Access specialist will fax your provider to confirm where the prescription should be sent.
- When you visit the pharmacy, present your SmithRx Member ID card. Please have your pharmacy add your copay card as a secondary payer.
- When your copay card expires, the pharmacy will realize a rejection and can assist you with renewing. If you encounter a higher-than-expected copay, reach out to the SmithRx Connect team.

MARK CUBAN COST PLUS DRUGS PROGRAM (MCCPD)

This program is designed to offer you savings on select medications through mail order - specifically for high-cost generic medications. **Here's how the program works:**

- If you are taking an eligible medication, you will be allowed **three transitional fills** while you enroll in the program. **If you do not enroll prior to the fourth fill, your claim will be rejected at the pharmacy.**
- SmithRx will reach out to you directly to inform you about the MCCP program. You can also initiate the process by calling 844.385.7612.
- The SmithRx team will help you enroll and transfer your prescriptions to a MCCPD account.
- Once you enroll, you can receive medications right at your doorstep, either at the cost of the mail order through your plan, or a specialty copay. You may even receive the medication at little to no cost.
- If you need a new prescription, SmithRx will coordinate with your provider to determine where it should be sent. You can also work directly with your provider to send the prescription.

Have Questions on Pharmacy?

If you have any questions about SmithRx Connect, reach out to SmithRx at 844.385.7612.

To see additional programs available through SmithRx, or to view a list of eligible medications through the Connect 360 Access Traditional Program, visit **mysilabenefits.com,** click "Your Benefits", and visit the "Prescriptions" tab.

Employee Assistance Program (EAP)

Life can be challenging—and sometimes, it helps to talk to someone. The Employee Assistance Program (EAP) through ComPsych is a free, confidential resource available to help you and your family navigate personal, emotional, and work-related concerns.

Whether you're feeling overwhelmed, dealing with stress, facing relationship issues, or just need guidance, the EAP offers:

- Unlimited free telephonic consultations with an EAP counselor available 24/7 at **855.239.0743.**
- Referrals to local counselors — **up to three sessions at no charge.**
- State-of-the-art website featuring articles on topics like wellness, training courses, and a legal and financial center.

The EAP provides counseling on all aspects of life, including:

- Difficulties in relationships
- Emotional/psychological issues
- Stress and anxiety issues with work or family
- Alcohol and drug abuse
- Personal and life improvement
- Legal or financial issues
- Depression
- Childcare and eldercare issues
- Grief issues

Additional Benefits Through ComPsych:

WILL PREPARATION

Will prep services through ComPsych offers a range of will preparation services. For members, the services include online planning documents, a resource library, and access to professionals to help with issues. Some of the services include:

- Complete a customized will: No cost to you.
- Have your will printed and sent to you: $14.99.
- Draft a living will: $14.99.
- Draft a final arrangements document: $9.99.

988 SUICIDE & CRISIS LIFELINE

If you or someone you know is in crisis, dial 988 for immediate, free, confidential support from a trained professional. The 988 Suicide & Crisis Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States.

Have Questions or Need Assistance with Challenges in Your Daily Life or Work?

Specialists are available for confidential 24/7 assistance and support.

Call: 855.239.0743
TRS: Dial 711

Download the mobile app by searching Guidance Now.

For more information about ComPsych, go to **www.guidanceresources.com**

Web ID: Guardian

Dental

Guardian | www.guardianlife.com | 888.482.7342

The Guardian network of dental providers is one of the largest in the nation. You may choose to see any provider you would like, but you will save money by using in-network providers.

You will have the option between the Base PPO and Buy-Up PPO outlined below. All preventive dental care is covered at 100% on either plan.

www.Guardianlife.com

View covered services, claim status or your account balance, find a dentist, update your information, download a digital ID card, and much more at **www.guardianlife.com.**

	BASE PPO (IN-NETWORK)	BUY-UP PPO (IN-NETWORK)
Deductible (Individual/Family)	$50 / $150	$50 / $150
Annual Plan Maximum	$1,000 + maximum rollover	$1,500 + maximum rollover
Services		
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia (children up to age 26)	No orthodontia coverage	50% coinsurance; up to $1,500 lifetime max

Find an In-Network Provider

- You may locate participating dental providers by accessing the Guardian website at guardianlife.com.
- Select **Find a Dentist** in the upper right of the screen.
- Click on the left tab - "Dental benefits bought through your workplace".
- Under the Find a Dentist header, choose **"PPO: DentalGuard Preferred"** as your plan type.
- Once you have completed the other requested information, click "Search."

Vision

Guardian | www.guardianlife.com | 888.482.7342

Guardian's vision care benefits include coverage for eye exams, lenses, frames, and contact lenses. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers in Guardian's VSP network. You can choose from two vision plans, outlined below:

To find an eligible provider, or download your digital ID card, register at **VSP.com**

	BASE PLAN		BUY-UP PLAN	
PLAN	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Eye exam with dilation as necessary (once per 12 months)	$10 copay	$39 allowance	$10 copay	$39 allowance
Frames (once per 24 months)	$25 copay; 80% of amount over $130 allowance	$46 allowance	$25 copay; 80% of amount over $200 allowance*	$46 allowance
Standard lenses				
Single vision	$25 copay	$23 allowance	$25 copay*	$23 allowance
Bifocal		$37 allowance		$37 allowance
Trifocal		$49 allowance		$49 allowance
Lenticular		$64 allowance		$64 allowance
(once per 24 months)				
Contact lenses in lieu of glasses				
Medically necessary	$25 copay	$210 allowance	$25 copay*	$210 allowance
Elective	$130 allowance	$100 allowance	$200 allowance	$100 allowance
(once per 24 months)				

**If you enroll the buy-up plan, your benefit frequency is once per 12 months for exam, lenses, contacts, and frames.*

Find an In-Network Provider

- You may locate participating vision providers by accessing the Guardian website at guardianlife.com.
- Select **Find a Vision Provider** in the upper right of the screen.
- Click on the center tab - "VSP".
- Search by provider, location, or office!

Commuter Benefits

Transportation Savings Account

If you reside in Philadelphia, PA; Chicago, IL; or New Jersey you are eligible to open a Transportation Savings Account. Sila offers commuter benefits through Wex. Commuter accounts are pre-tax benefit accounts used to pay for public transit — including train, subway, bus, ferry or vanpool — as part of your daily commute to and from work. It's a great way to put extra money in your pocket each month and make your commute more convenient and affordable.

A commuter expense reimbursement account allows you to use pre-tax dollars to pay parking and commuter costs to and from your place of work. You can deduct up to $340* per month on a pre-tax basis. You are also allowed additional deductions post-tax into accounts for parking costs and/or transit costs.

**Annual contribution limit subject to change per IRS ruling.*

Eligible Expenses: Transit

A Transit Account enables you to set aside funds on a pre-tax basis to pay for eligible workplace mass transit expenses such as the price of tickets, vouchers, and passes to ride a subway, train or city bus, or the costs of transportation in a commuter highway vehicle (e.g., vanpool), if such transportation is for purposes of travel between a residence and place of employment.

Eligible Expenses: Parking

A Parking Account enables you to set aside funds on a tax-free basis to pay for eligible workspace parking expenses, parking costs at or near your primary work site as well as parking costs at the place to access transportation to work, such as a train station or vanpool stop. Parking on or near property used for residential purposes does not qualify.

Have Questions on Your Commuter Benefits?

Questions when enrolled: 866.451.3399

Questions before you enroll: 844.561.1337

Submit questions at **www.wexinc.com**

Health Savings Account (HSA)

You are Eligible to Open and Fund an HSA if:

- You are not enrolled in any other non-HSA qualified health insurance plan.
- You are not covered by your spouse's plan (unless it is a qualified HDHP), flexible spending account (FSA), or health reimbursement account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, TRICARE, or TRICARE For Life.
- Care received through the VA in the preceding three calendar months was dental, vision, or preventive care, or was provided to a veteran who has a disability rating from the VA.

HSAs Offer You the Following Advantages:

- **Tax savings:** You can contribute pre-tax dollars to the HSA. Sila will also contribute to your HSA for 2026. Interest accumulates tax-free, and funds are withdrawn tax-free to pay for medical expenses.
- **Reduced out-of-pocket costs:** You can use the money in your HSA to pay for eligible medical, dental, vision, and prescription expenses. The HSA funds you use can help you meet your plan's annual deductible.
- **A long-term investment that stays with you:** Unused account dollars are yours to keep even if you retire or leave the company. Also, you can invest your HSA funds, so your available healthcare dollars can grow over time.

Eligible Expenses

Eligible expenses for reimbursement are those you pay out of your pocket for healthcare that is provided to you, your spouse, or your eligible dependents. Eligible expenses include:

- Medical copays, coinsurance and deductibles
- Dental exams, cleanings, X-rays and braces
- Vision exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services, such as physical therapy, chiropractic, and acupuncture
- Prescription drugs and insulin

(Visit IRS Publication 502 for a full list of eligible expenses)

Optum Bank

A Health Savings Account (HSA) is a personal healthcare bank account that you can use to pay out-of-pocket medical expenses with pre-tax dollars. **If you enroll in the White medical plan, Sila will automatically open an HSA for you.**

Sila will contribute $500 if you enroll as an individual and $1,000 if you enroll with dependents. Remember, Sila's contribution counts towards the annual IRS limit. Plan carefully so you don't overcontribute to your accounts!

2026 CONTRIBUTION LIMITS*

	IRS Maximum	Sila Contribution	Eligible Employee Contribution
Employee Only	$4,400	$500	$3,900
Employee + Family	$8,750	$1,000	$7,750

**Subject to change per IRS guidelines. $1,000 catch-up contribution if over 55*

Sila's contribution is made when you enroll. It is prorated if you join the plan mid-year.

Sign in online through Optum Bank to:

- Check your balance
- Manage your contribution
- Reimburse yourself
- Pay a bill

Disability

Guardian | www.guardianlife.com | 888.482.7342

Short-Term Disability (STD)

Sila's short-term disability coverage provides 60% of your pre-disability weekly earnings up to a maximum of $1,500 per week. There is a 7-day waiting period.

Short-term disability benefits are designed to replace a portion of your income for a non-work-related short-term injury or illness.

The STD benefit is paid for by Sila; there is no cost to you. However, any income replacement benefits received are taxable.

SHORT-TERM DISABILITY ELIGIBILITY - FULL-TIME EMPLOYEES	100% PAID BY SILA
Weekly benefit amount	60%
Weekly benefit maximum	$1,500
Benefits duration	12 weeks
Waiting period	7 days

Please note, if you live in a state that offers state disability insurance, you may be eligible for income replacement through the state if you're unable to work due to a non-work-related illness, injury, or pregnancy. Sila's STD benefits may be offset by the coverage you receive directly though the state. Connect with your HR team to better understand your coordination of benefits.

Short-Term Disability in Action - Example Below!

Taylor recently had surgery and needs time to recover before returning to work. Since the recovery period is expected to last several weeks, Taylor qualifies for short-term disability benefits, which help replace a portion of their income while they're unable to work.

Taylor works with Lockton On Call to file a claim and begins receiving STD benefits after the required waiting period. These benefits provide financial support during recovery, so Taylor can focus on healing without worrying about lost wages.

Long-Term Disability (LTD)

Sila's long-term disability coverage provides 50% of your pre-disability monthly earnings up to a maximum of $2,500 per month after 90 days of disability.

Long-term disability offers financial protection to you when you need it most — if you become disabled and can no longer work. **The base LTD benefit is paid for by Sila; there is no cost to you.**

LONG-TERM DISABILITY ELIGIBILITY – FULL-TIME EMPLOYEES	BASE PLAN (100% PAID BY SILA)
Monthly benefit amount	50%
Monthly benefit maximum	$2,500
Benefits duration	Lesser of 2 years or to age 70
Waiting period	90 days

You also have the option to purchase buy-up long term disability. You can purchase coverage that provides you with 60% of your pre-disability monthly earnings up to a maximum of $10,000 per month. Your weekly premiums are based on your age.

BUY-UP PLAN (100% PAID BY YOU)	
Monthly benefit amount	60%
Monthly benefit maximum	$10,000
Benefit duration	Social Security Normal Retirement Age
Waiting period	90 days

Note: Your benefit amount may be offset by other benefits you are receiving, such as Social Security or workers' compensation. Your monthly benefits are subject to federal income tax and may be subject to state and local taxes.

Please note, you may be requested to submit Evidence of Insurability (EOI) if you elect buy-up long-term disability coverage. Remember, if you chose to waive this coverage when you were first eligible, you will be subject to medical underwriting.

Evidence of Insurability can be satisfied through written or electronic health statements, as well as certain medical examinations. When electing these benefits online, you will be able to complete the statement of health.
To submit EOI visit **www.guardiananytime.com/eoi.**

Life and AD&D Insurance

Guardian | www.guardianlife.com | 888.482.7342

Basic Life and AD&D

Sila provides a flat $50,000 life insurance benefit for all full-time eligible employees. **This benefit is offered to you at no cost.**

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. Accidental Death and Dismemberment (AD&D) provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight or hearing, or if you die in an accident.

GROUP TERM LIFE AND AD&D	100% PAID BY SILA
Employee	Flat $50,000

If you are over the age of 65, benefits are reduced by 35%. If you are over the age of 70, benefits are reduced by 50%.

Important - Beneficiary Updates

If you are eligible, you will be automatically enrolled in Basic Life and AD&D, paid for by Sila.

Even if you do not plan on enrolling in additional benefits, log into ADP to update your beneficiaries, in the event payout is applicable.

If you do not update your beneficiary, you will NOT receive the benefit.

Voluntary Life and AD&D

You can purchase coverage in increments of $10,000 up to $250,000.

You, your spouse, and your children are eligible for voluntary life and AD&D insurance coverage if you are an active full-time employee. You are able to select coverage for your spouse and dependent children if you elect voluntary coverage for yourself. Voluntary life insurance is portable based on age and other restrictions.

Please note, you may be requested to submit Evidence of Insurability (EOI) if you elect voluntary life coverage over the guaranteed issue amount. Remember, if you chose to waive this coverage when you were first eligible, you will be subject to medical underwriting regardless of the amount you elect.

Evidence of Insurability can be satisfied through written or electronic health statements, as well as certain medical examinations. When electing these benefits online, you will be able to complete the statement of health.
To submit EOI visit **www.guardiananytime.com/eoi.**

COVERAGE	AVAILABLE BENEFIT	GUARANTEED AMOUNT
Employee $10,000 increments	Up to $250,000	$200,000
Spouse $5,000 increments	Up to $250,000 (cannot exceed 100% of employee coverage)	$50,000
Dependent child(ren) $5,000 increments	Up to $10,000 (cannot exceed 100% of employee coverage)	$10,000

Please be aware that your AD&D benefit amount may decrease 35% at age 65, and 50% at age 70.

Supplemental Health Benefits

Guardian | www.guardianlife.com | 888.482.7342

Supplemental health insurance through Guardian can help protect you from significant or unexpected out-of-pocket expenses that aren't covered under your medical plan. Consider your anticipated medical needs along with the cost of the insurance plans available to you. Keep in mind, these plans are intended to supplement, not replace, a medical plan.

CRITICAL ILLNESS INSURANCE

Guardian critical illness insurance supplements your medical plan. Guardian pays you cash benefits based on each eligible diagnosis. The cash benefits are paid directly to you — you decide how to use them. Examples of covered conditions include strokes, heart attacks, Parkinson's disease, and cancer.

ACCIDENT INSURANCE

Even with medical insurance, a fall while biking, or your child's sprained ankle at soccer practice, can cost you. In the case of an accident, Guardian pays you cash benefits based on covered injuries, treatments, and services. Payments go directly to you, and you can pay for other expenses, like hospital travel, childcare, and lost income from missed work.

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance is designed to help provide financial protection for you by paying a benefit due to hospitalization. You can use the benefit to cover the out-of-pocket expenses and extra bills that can occur. Indemnity lump-sum benefits are paid directly to you based on the amount of coverage listed, regardless of the actual cost of treatment. The option of electing spouse and/or dependent coverage is also available.

If you complete a routine wellness screening or procedure, such as colonoscopy, mammogram, fasting blood work, or flu vaccine, you can earn a $50 wellness benefit for your participation in the Critical Illness and Accident plans.

You can enroll in any of the supplemental plans even if you are not enrolled in a Sila medical plan.

Your Coverage in Action!

Bob has critical illness insurance and suffered a heart attack. Then had a stroke a few years later.

- Medical insurance covers most of the cost but he is left with some out-of-pocket costs.
- His critical illness insurance paid him a lump sum benefit for both illnesses.
- Bob uses his benefit payment for out-of-pocket expenses and has money left over for a well-deserved vacation.

Sue has accident insurance and tore the cartilage in her knee.

- Medical insurance covers most of the cost but they are left with some out-of-pocket costs.
- Sue's accident insurance paid her a lump sum benefit for her covered injuries, an MRI, knee brace and follow-up doctor visits.
- She uses this benefit payment to pay off her out-of-pocket expenses and even has money left over for a camping trip.

Kevin has hospital indemnity insurance and became ill and was admitted to the hospital.

- Medical insurance covers most of the cost but he is left with some out-of-pocket costs.
- Kevin's hospital indemnity insurance paid him lump sum benefit for being admitted to the hospital for 2 days.
- Kevin uses this benefit payment to pay his out-of-pocket expenses and even has money left over for some video games.

401(k) Retirement

VANGUARD

Sila welcomes and encourages you to participate in the 401(k) retirement plan. This plan offers tax free savings for the future and retirement. You can enroll in the 401(k) plan on a quarterly basis — January 1, April 1, July 1, and October 1. For additional information and questions regarding plan selection, please go online to my.vanguardplan.com

- Part-time and full-time employees who have worked at least 3 months, and are over the age of 21, will be automatically enrolled and contributing 2% to their 401(k). If you want to change your contribution amount, or if you would like to opt out of the program altogether, you need to register for an account and login by visiting my.vanguardplan.com.*
- The longer your money stays in your account, the more opportunity it has to grow over time through compound interest.
- You can invest your account in a mix of mutual funds, stocks, and bonds to help it grow even more.
- Because you contribute pre-tax dollars, your contributions and any earnings are tax-free when you take them out (you must be age 59-1/2 or older to receive a distribution without penalty)!

Beneficiary Designation

An important aspect of estate planning is making beneficiary designations and keeping them up to date after life changes. It's generally quick and easy to assign or update your beneficiary designation by visiting **my.vanguardplan.com**. You will need to provide the name and Social Security number of each beneficiary. If you cannot complete the designation online, you can obtain a paper form.

2026 CONTRIBUTION LIMITS**

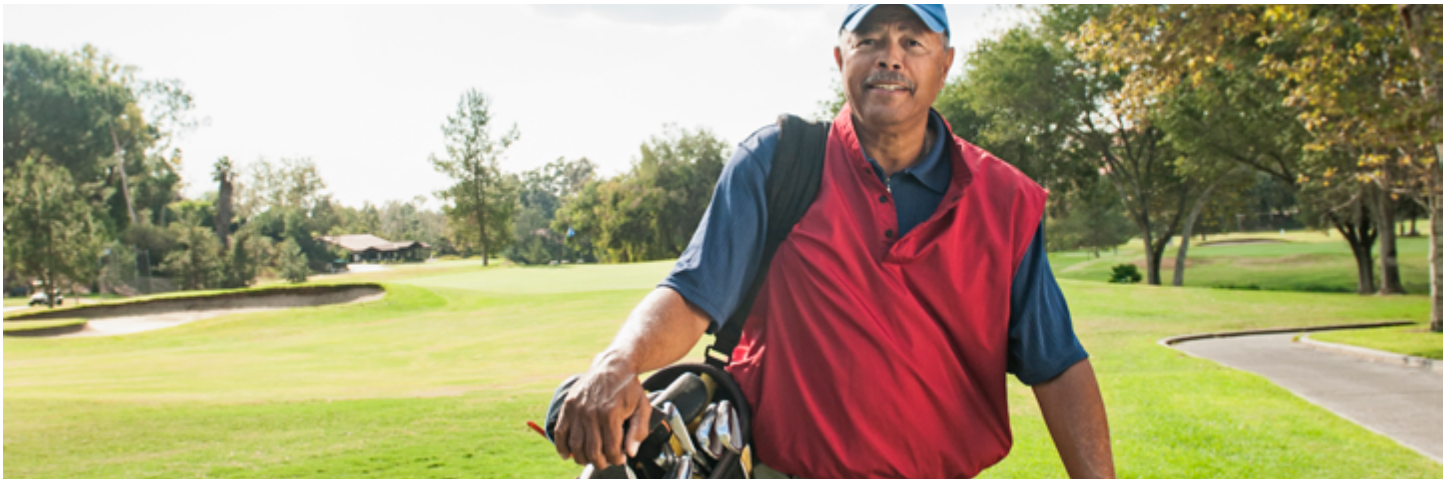
You can contribute up to $23,500 in pre-tax or Roth contributions to the Retirement Plan in 2026. Plus, if you are age 50 or older, you can contribute an additional $7,500 in catch-up contributions to the plan. If you are ages 60 to 63, you can contribute an additional $3,750 in catch-up contributions for a total of $11,250.

If you have any questions, please contact Vanguard at 877.662.7447.

Retirement specialists are available Monday through Friday, 8am to 10pm Eastern Time. You can also reach out to **benefits@sila.com** for help with the enrollment process.

**Sila follows a three-year cliff vesting schedule. Under a three-year cliff vesting schedule, participants are 100% vested in the employer contributions when they are credited with three years of vesting service but are 0% vested at all prior points.*

*** Subject to change per IRS guidelines.*



Your Rates and Contributions

MEDICAL/RX (WEEKLY CONTRIBUTIONS)	ORANGE PLAN	WHITE PLAN	BLUE PLAN
Employee	$50.06	$41.21	$22.95
Employee + Spouse	$123.70	$103.53	$63.44
Employee + Child(ren)	$93.64	$75.57	$37.39
Family	$132.94	$112.31	$65.18

DENTAL (WEEKLY CONTRIBUTIONS)	BASE PPO	BUY-UP PPO
Employee	$4.41	$5.36
Employee + Spouse	$8.86	$10.72
Employee + Child(ren)	$11.00	$12.89
Family	$14.92	$18.25

VISION (WEEKLY CONTRIBUTIONS)	BASE PLAN	BUY-UP PLAN
Employee	$0.61	$1.10
Employee + Spouse	$1.16	$2.08
Employee + Child(ren)	$1.37	$2.45
Family	$1.92	$3.44

ACCIDENT (WEEKLY CONTRIBUTIONS)	100% PAID BY YOU
Employee	$3.89
Employee + Spouse	$6.53
Employee + Child(ren)	$6.93
Family	$9.57

HOSPITAL INDEMNITY (WEEKLY CONTRIBUTIONS)	100% PAID BY YOU
Employee	$2.88
Employee + Spouse	$7.99
Employee + Child(ren)	$5.56
Family	$10.68

VOLUNTARY CRITICAL ILLNESS PLAN RATES EMPLOYEE AND SPOUSE	
AGE RANGE	WEEKLY RATE (PER $1,000 OF COVERAGE)
15–29	$0.113
30–39	$0.192
40–49	$0.378
50–59	$0.780
60–69	$1.355
70–99	$2.169

VOLUNTARY LIFE PLAN RATES EMPLOYEE AND SPOUSE	
EMPLOYEE AGE	WEEKLY RATE (PER $1,000 OF COVERAGE)
15–29	$0.030
30–34	$0.031
35–39	$0.039
40–44	$0.059
45–49	$0.093
50–54	$0.150
55–59	$0.238
60–64	$0.343
65–69	$0.580
70–99	$1.169

BUY UP LTD	
AGE RANGE	WEEKLY RATE (PER $100 OF COVERED PAYROLL)
15–22	$0.018
25–29	$0.021
30–34	$0.042
35-39	$0.069
40–44	$0.104
45-49	$0.164
50–59	$0.217
55–59	$0.284
60-99	$0.270

VOLUNTARY LIFE PLAN RATES CHILD(REN)	
CHILD(REN)	WEEKLY RATE (PER $1,000 OF COVEAGE)
Based on child(ren) age	$0.039

VOLUNTARY AD&D PLAN RATES	
TIER	WEEKLY RATE (PER $1,000 OF COVERAGE)
Employee	$0.013
Spouse	$0.013
Child(ren)	$0.013

Important Contacts

Sila Human Resources | Email: benefits@sila.com | Call: 610.491.9409

Lockton On Call | Email: silabenefits@lockton.com | Call: 866.430.0125

	CARRIER	CUSTOMER SERVICE NUMBER	WEBSITE	GROUP NUMBER
Medical Plan	Highmark	Member services: 800.241.5704	highmark.com	
Prescription Drugs	SmithRx	844.454.5201	Smithrx.com/members	76415802
Health Savings Account	Optum Bank	866.234.8913	www.optumbank.com	907474
Commuter Benefits	WEX	If Enrolled: 866.451.3399 Before Enrolled: 844.561.1337	www.wexinc.com	43642
Vision	Guardian	800.627.4200	www.guardianlife.com	00028192
Dental	Guardian	800.627.4200	www.guardianlife.com	00028192
Life and AD&D Insurance	Guardian	800.627.4200	www.guardianlife.com	00028192
Short- and Long-Term Disability	Guardian	800.627.4200	www.guardianlife.com	00028192
Employee Assistance Program	Guardian	855.239.0743	www.guidanceresources.com Web ID: Guardian	
401(k) Retirement Plan	Vanguard	877.662.7447	my.vanguardplan.com	

Sila Services, LLC

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Sila Services, LLC About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM SILA SERVICES, LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sila Services, LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Sila Services, LLC has determined that the prescription drug coverage offered by the Sila Services, LLC Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as

Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Sila Services, LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Sila Services, LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Sila Services, LLC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Sila Services, LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information, or call 484-509-0695. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Sila Services, LLC changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2026
Name of Entity/Sender:	Alexis Freeman
Contact—Position/Office:	Senior HR Generalist
Address:	900 E. Eighth Ave., Suite 106 King of Prussia, Pennsylvania 19406
Phone Number:	484-509-0695

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

SILA SERVICES, LLC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Sila Services, LLC Health and Welfare Benefit Plan *

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Sila Services, LLC is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not

otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Alexis Freeman
Senior HR Generalist
484-509-0695

Effective Date
The effective date of this notice is: January 1, 2026.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

SILA SERVICES, LLC EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Alexis Freeman
Senior HR Generalist
484-509-0695

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:
Alexis Freeman
Senior HR Generalist
900 E. Eighth Ave., Suite 106
King of Prussia, Pennsylvania 19406
484-509-0695

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Sila Services, LLC Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 484-509-0695.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Sila Services, LLC Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Sila Services, LLC Employee Health Care Plan at:

Alexis Freeman
Senior HR Generalist
484-509-0695

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Sila Services, LLC Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Sila Services, LLC Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Alexis Freeman
Senior HR Generalist
484-509-0695

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Alexis Freeman, Senior HR Generalist, 484-509-0695.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Employer Name:	Sila Services, LLC.
Employer State of Situs:	Pennsylvania
Name of Issuer:	UMR
Plan Marketing Name:	Gold PPO, Silver HDHP, Bronze PPO
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	No
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes

24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	No
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	No
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	No
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

Sila SERVICES